PUBLIC STATEMENT
ON THE HEALTH CARE FUNDING CHALLENGE
Turks & Caicos Islands Government
October 10th 2011

Statement

The decision was taken, in 2003, to invest in significantly improved secondary healthcare infrastructure and services, and to extend the benefit of state-funded healthcare to all residents of the Turks and Caicos Islands (TCI), rather than just Belongers. This was one part of an ambitious five-pillared Health Care Renewal Strategy. At the time of the project's inception the TCI was undergoing a major transformation both in terms of economic and population growth. Today the Turks and Caicos Islands and the TCI Government (TCIG) finds itself in a totally different economic and financial situation. As a result, large parts of the strategy have yet to be implemented and the total expenditure on health care (funded either through the National Health Insurance Plan (NHIP) contributors or by the taxpayer through the Treasury's general fund) is in excess of $60 million.

To summarise, the total annual cost of health care is approximately $61.5 million, broken down as follows:

Infrastructure Costs

- $20 million is paid to Interhealth Canada Limited (ICL) for infrastructure and equipment costs which can be seen as a long term investment in the country's healthcare facilities.

Clinical costs

- $24 million is paid to ICL for "Clinical Services". This represents the operational costs of the hospitals
- $12 million paid to NHIP for Overseas Treatment Costs. The NHIP paid out just over $9 million on overseas care and applied the balance to fund the Wards of the State, pharmaceutical program and payments to local private primary care practitioners.
- $5.5 million spent on the Government Primary Health Care programs, including emergency services, and mental health and long-term care.

Funds raised from the NHIP contributors are approximately $19 million. At $60 million the total national healthcare bill is 7% of GDP. TCIG pays $42 million of this amount on infrastructure, medical referrals and other government health costs accounting for about 25% of the government's $171 budget. In the developed countries average healthcare costs represent about 9% of GDP. On this statistic the TCI compares well. However health cost as a percent of government expenditure in the Caribbean is about 15%; therefore at 25% of the government's expenditure, healthcare costs in the TCI are unusually high and unsustainable.

The TCIG is thus taking a broad based initiative to seek a consensus on the way forward.

The Health Care Renewal Strategy

The Health Care Renewal Strategy (HCRS) which was developed in 2006 was a continuation and expansion of the Health Sector Development Strategy (HSDS) which was funded by DFID in 2000 **(See Annex 1)**. The main recommendations coming out of the DFID funded HSDS was the need for improved health infrastructure at both the secondary and primary care levels. The other was the establishment of an office of Procurement of Health Services for an effective mechanism for management and procurement of health services locally and overseas.

The HCRS was based on the five pillars:

- Improving the local delivery of secondary and tertiary care services by the construction of two hospitals
- Upgrading of Primary Health Care
- Development of a Healthy Lifestyles Initiative
- Establishment of a National Health Insurance Plan (NHIP) as a health financing mechanism, and
- Enactment of health sector regulatory mechanisms including the formation of a Health Regulatory Authority (HRA) which would govern and monitor many aspects of the healthcare delivery process.

To date the development of the new hospitals and the implementation of the NHIP are the only components of the HCRS that have been fully implemented.

In 2008, TCIG entered into a Public –Private Partnership with Interhealth Canada to design, build, commission and operate a 20 bed facility in Providenciales and a 10 bed facility in Grand Turk. Both medical facilities have a 100% bed expansion capacity. The costs incurred in construction, staffing, equipment purchase, project management, financing and commissioning, as outlined in the contract are $124M, of which some $65M is the cost of construction, amortised over 25 years.

With regards to the Interhealth Canada contract, penalty clauses are such that any “termination” event would cost TCIG around $128M. Therefore the assumption to date has been that the cost of continuing with the project is less than termination.

National Health Insurance Plan

The NHIP was established as one of the key financing mechanisms for the health care system. The objective was to reduce the financial burden on the TCIG for health care services by sharing it with potential users of the health care system. The NHIP contributions were designed to fund the Clinical Services costs of the hospitals, with the capital and facilities management charges being covered by TCIG. Based on actuarial advice the level of individual and employer contributions was set at 5% of total income, equally paid by employer and employee.

In the NHIP unaudited financial statements fiscal year 2010/11, payments to ICL accounted for some $23,454 million or 63.1% of NHIP expenditure. Overseas Medical Expenses accounted for $9,040 million or 23.3% of NHIP expenditure. This combined amount represents 87.4% of the total NHIP expenditure. The overseas costs are incurred because in a small community it is not possible to provide all secondary/hospital level services locally. The contractual capabilities of ICL in terms of infrastructure and staffing clearly impact the level of care provided in the TCI and thus the number of cases requiring overseas referrals. Cost containment has already been implemented by utilizing regional specialist centres of care and specialists when appropriate and possible.

NHIP Revenue

During the same period fiscal year 2010/11, the NHIP collected approximately $19 million in contributions and was paid $13 million from the TCIG for a total income of $32 million. This left a shortfall of $4 million, against payments to ICL of $24 million and to Overseas/Pharmacy/ Local practitioners of $12 million. The shortfall is exacerbated by the increased number of Wards of the State, those individuals who are unemployed, on long term disability, prisoners or pensioners. This is a direct reflection of the depressed economy.

Several further issues related to the current structure are important to note. The NHIP was delegated responsibility for managing the overseas treatment in conjunction with ICL. However, payment associated with this part of the plan remains the responsibility of TCIG, whilst under the regulations only ICL can initiate overseas referrals which are then managed in conjunction with the NHIP.

Treatment abroad is a complex issue. However, the NHIP has successfully reduced the cost from $36 million for 10,000 Belongers in 2008 to just over $9 million for over 30,000 beneficiaries. This has occurred in part through a managed move from U.S. facilities to regional facilities and in part because ICL has been able to offer a wider range of services on-island. But there needs to be efforts towards further cost reduction where possible.

Through a re-insurance scheme with a company called Redbridge Re-insurance, the NHIP has been able to insure against the exceptional claims (up to a limit per individual claim of $200,000.00 up to $1 million), that will normally arise in any population. At a rate of $3.54 per beneficiary, this has proven to be beneficial to the plan to date and has generally worked as intended, however a number of exceptionally expensive overseas treatments have been necessary, which cost more than the re-insurance limit and this has contributed to the cost over-runs at NHIP.

Illegal immigrants do not make any contribution to the Plan through any mechanism, but are entitled to and require treatment on humanitarian grounds and under international accords and agreements. The healthcare treatment costs related to illegal immigrants have been higher than NHIP's original actuarial assumptions allowed for.

TCIG Revenue

TCI has undergone a major economic contraction with substantially decreased government revenues from nearly all sources. Thus the funds available to TCIG and by extension the community have to be carefully allocated to priority areas. It is therefore imperative that a sustainable level and mechanism of funding for healthcare is devised that reflects the current situation and that of the foreseeable future.

Current Health Care Challenges

Clearly in spite of the opening of the ICL hospitals many challenges previously experienced remain. These challenges are in part due to the lack of implementation of the other components of the HCRS **(See Annex 2 in detail)**.

The relative cost of the mechanism for delivering secondary care under the current hospital contractual arrangement has placed an unexpected yet unsustainable burden upon the TCIG and NHIP. This relative increase in cost has arisen due to the change in the global, regional and local economy with the associated demographic changes in the TCI.

Health care in the TCI is currently being delivered by a number of providers and with several payment mechanisms. Of these ICL is the number one care provider by law as the preferred provider.

It is obvious that TCIG pays for the major portion of the total health care delivery cost. This being the case and with the current financial position of TCIG, the Ministry of Health has had to suspend or downsize a number of its programmes. These include closure of the AIDs Hospice in Providenciales, and merger of the residential homes in South Caicos and Grand Turk for persons with special needs. Operation of the Animal Pound in Grand Turk was also suspended.

Pharmaceuticals and their delivery to the population remain a challenge and this section of the plan appears to have mushroomed for reasons which at this time are not entirely clear. However there appears to be a reasonable argument made that the current co-pay waiver list may be too large. The prescribing practices of the medical community and the amount of TCIG contribution to pharmaceutical costs need to be assessed to determine the most efficient use of taxpayer resources to ensure access to medication for all who need it at minimum TCIG cost.

The current health care challenges can be summarized as follows:

1. Between the two funding sources (NHIP and TCIG), there are currently insufficient funds to fund the delivery of health care as mandated by NHIP benefits regulations, TCIG/ICL Hospital contract obligations and Primary Health Care and Public Health needs.

2. Inadequate funding of Primary Health Care to implement effective health promotion and disease prevention and control programmes which should

reduce morbidity and mortality and thus a concomitant reduction in expenditure on secondary and tertiary care services in the medium and long term.

3. Possible ineffective drug procurement and distribution programme that may be too costly to the purchaser and the end user alike. This is an area that requires careful assessment and review by an independent team with expertise in this area.

4. A continued requirement for secondary and tertiary health care services relative to our ability to afford them. These costs can be difficult to plan for completely.

5. High cost for medical treatment overseas continues to threaten the sustainability of the programme due to an open door, no limit policy as required by current legislation

6. Poor health information systems which results in inadequate data and information for effective evidence based decision making (**See Annex 3 for Details)**

7. Complete and unrestricted funding of healthcare for "Migrant workers" due to

    a. Lack of Migrant health policy

    b. Unlimited funding and duration thereof for medical care overseas for persons who are not permanently resident in the TCI

    c. Unlimited funding of dependents regardless of the number of dependents

OPTIONS

Reduce Costs

1. Review of the ICL contract by both ICL and the TCIG to see if there is any room to modify or renegotiate the contract to reflect the current economic situation. The goal would be to reduce the cost of clinical services provided by adjusting the clinical cost formula. There could also be a cap on the provision of primary care services from the hospital. This will reduce the cost of providing primary care in a hospital setting under a contract.

2. Reduce the range of services that are funded by NHIP/TCIG. There may be some services that TCIG/NHIP could stop funding for those other than pensioners and the disadvantaged. Debates in the UK and other countries supplying social medical programs tend to focus for instance on the extent to which the state should fund dental care and optical care and some defined “non essential” types of medical intervention.

3. Limit the range of people whose care is fully funded by the state. Under the existing Legislative frame work, migrant workers can register one day and receive coverage the same day. These individuals may only be resident in the TCI for relatively short periods of time, and in the case of the domestic workers, and laborers, are only making minimal payments for coverage of themselves and their dependants. A two tier policy differentiating long term residents and short-term residents with different benefit packages might be an option.

4. Cap or limit NHIP benefits. The NHIP regulations already outline which services are offered to its members on a limited basis or totally excluded. However, one of the greatest risks to the sustainability of the NHIP fund is the open ended and unlimited nature of its treatment abroad policy. Medical treatment overseas is available to all members without a cap, deductible, or duration. Both 3 and 4 are difficult options

5. NHIP could fund the delivery of TCIG primary health care programmes by several methods:

- Support the current TCIG clinics by adequately funding the operational cost i.e. staff, supplies, infrastructure up-keep.

- Pay TCIG for services provided to NHIP beneficiaries and TCIG continue to fund primary health care,

- Support private clinics by increasing the funding of private sector delivery of primary care services from $35 per visit based on actuarial assessment. This would have the effect of reducing unnecessary emergency room visits,

decreasing the need to invest heavily in government community clinics at this time of limited resources, and also reducing the demand on existing TCIG operated clinics as primary care patients are shunted from ICL.

6. The NHIP could consider developing a drug programme similar to the Jamaica National Health Fund (NHF) and Jamaica Drug for the Elderly Programme (JADEP) or the Bahamas National Prescription Drug Plan. This entails NHIP paying for drugs for specific illnesses. This system however will exclude certain routine drugs like antibiotics.

7. Competitive Tendering for Drugs. A system should be developed whereby there is more robust competitive tendering and the NHIP pays for the provision of drugs to all its beneficiaries through all participating pharmacies, including those that may be operated by NHIP. The pharmaceutical procurement process is fragmented and we may not be getting value for money as we are not maximizing on benefits of competitive tendering and bulk procurement. A central clearing/ordering agency controlled by TCIG/NHIP might allow for bulk ordering.

Increase Revenue

1. All beneficiaries contribute to the plan. Currently only those who are employed contribute. There are approximately 11,000 dependants being supported by 18,000 contributors. If each spouse paid the minimum monthly contribution of $25 and each family contributed up to a maximum of 2 children at $10 (the final figure to be determined by actuarial projected calculations) the fund could increase its income.

2. Increase the contribution rate to a higher percentage.

3. Establish a minimum contribution rate of $25 per month.

4. Increase co-payments for services provided.

5. Allow voluntary contributions by long-term residents currently not eligible, retired person and winter visitors. These could be for a full benefits package or a local treatment only package.

6. Apply "sin tax" to tobacco, alcohol and high sugar content products which is specifically allocated to the healthcare budget.

7. Increase revenue by encouraging health tourism. The current hospital contract allows TCIG to benefit from 50% of any net revenues generated by third party revenues and there are endorsed plans to introduce prostate and cosmetic treatments that should net TCIG a minimum of $2 million per annum. Discussions are also being held with a third party, that if successful, would lead to a major change in the services provided on Grand Turk. These would

complement the existing services, reduce the dependency on overseas treatments and raise significant revenue.

Immigration

Introduce an immigration migration policy. This should be restricted only to first world countries and other Overseas Territories. This would increase the tax base and lessen the burden on the small population. There are social and cultural issues associated with this option.

Final Questions for Consideration

1. **Should the Government aim to re-negotiate the contract with ICL?**
2. **Should the present NHIP financial imbalance be addressed by increasing contribution rates, or reducing benefits, or both?**
3. **Should NHIP contributors with dependants pay higher contributions than those without dependants, if they can afford to?**
4. **Should co-payments on pharmaceuticals, dental and optical care be increased for those that can afford them?**
5. **Should co-payments be introduced for all healthcare treatments, except for those that cannot afford them?**
6. **Should a minimum residency period apply to membership of the NHIP and new immigrants would only receive the minimum benefits required under international conventions?**
7. **Should NHIP benefits be restricted to urgent treatments only?**
8. **Should medical practitioners be expected to take their share of reducing healthcare costs?**

Notes to the Public:

1. The Government invites comments from the general public on the proposed options
2. All comments should be emailed to tcihealthcarefunding@gmail.com and/or mailed to:

   CEO Turks and Caicos Islands Public Service
   C/o Tito Lightbourne
   NJS Francis Building
   Grand Turk

3. The cut-off date for comments is October 31st 2011
4. The Ministry of Health & Human Services will be producing a follow-up paper which provides details and costings of the various options.

Annex 1.

The Health Care Renewal Strategy

The development and implementation of the HCRS was based on the "five pillars":

- Improving the local delivery of secondary and tertiary care services by the construction of two hospitals with the effects of:
    - Improving quality of care delivered locally with accepted outcomes
    - Reducing referral overseas for medical treatment and associated costs
    - Ensuring a predictable and affordable cost for delivery of secondary and tertiary care locally

- Primary Health Care Renewal which included:
    - The improvement in the primary care clinics infrastructure with development of new community based clinics and extension and refurbishment of others
    - Development of more comprehensive service at the family island community based clinics with integrative linkages to hospital facilities and services
    - Sustainable, predictable and more secure financing mechanism for the delivery of primary health care
    - Establishment of a quality assurance system
    - Robust health information system to improve surveillance & control diseases
    - Improved community based nursing programme and more elaborate partnering with health NGOs

- Healthy Lifestyles Initiative with an emphasis on reducing the incidence of Non Communicable Diseases such as diabetes, hypertension, cancer and cardiovascular related disorders and thereby reducing the expenditure on secondary and tertiary care and referral overseas for medical care.

- Establishment of a NHIP as a health financing mechanism to achieve the following:
    - Reduce TCIG burden for the payment for health care services by sharing it with potential users of the health care system.
    - Effective collection of funds from residents and ring fencing it for the procurement of health care services
    - Effective and efficient procurement of health services overseas and locally
    - Effective auditing, reconciliation and administration of clinical services locally and overseas.
    - Equity in accessing health services locally
    - Affordability of health care services by all
    - 100% of the population having access to at least basic primary health care services

- Health sector regulatory mechanism that seeks to have a more effective regulation of the following aspects of the health sector:
    - Registration and licensing of hospitals and health facilities
    - Registration and licensing of health professionals
    - Setting of health care standards and regulation thereof
    - Regulation of pharmaceuticals and new technologies
    - Health information protection and regulation of health research

Annex 2

The summary health status of Turks and Caicos Islands over the past 10 years points to the following picture:

- Increasing burden of diseases due diabetes, hypertension, obesity, cardiovascular diseases, cancer, kidney diseases and complications and advanced stages of these diseases due to sedentary lifestyles and increased consumption of processed foods including those with high fat and sugar contents.

- Increased incidence of HIV and related diseases but a decline in AIDS related deaths.

- Limited resources to operate effective communicable diseases surveillance and control system, along with the constant threat from major communicable diseases of national public health and international concern.

- Prior to 2010 inadequate capacity and funding to deliver high quality secondary care and some tertiary care services due to limited space, dilapidated health facility infrastructure, limited specialist services and limited health administration capacity within the Ministry of Health.

- Exponential increase in expenditure on medical treatment overseas between 2001 and 2009, to the point of being unsustainable due to increased disease burden, poor control mechanisms and poor administration and management of overseas treatment by contracted third party administrators.

- Unpredictable financing in the delivery of health services due to the exorbitant amount of funds being spent on medical treatment overseas and over reliance on public purse for the financing of health care. This resulted in the implementation of the NHIP in 2010 to correct these challenges.

- Poor health infrastructure and health services delivery mechanisms due to manpower shortages and material resources. This was alleviate to some extent with the development of the new hospitals

- Poor health information systems which resulted in inadequate data and information for effective evidence based decision making. Development of the new hospitals and establishment of the NHIB with high end information technology services in 2010 helped to address some of the information gap challenges, but major challenges still remains.

Annex 3.

Baseline Data Requirements

1. Total Expenditure on Health Care

    a. Annual Infrastructure, technology and clinical cost for delivery of care at the hospitals (this should include the projected capitation cost for clinical services).
    b. TCIG cost for the delivery of Primary Health Care, Dental Health, Mental Health and Wellness Center (Geriatrics, long term care and Special needs). This should include what is considered reasonable to provide the level of service needed to have an effective Primary Health Care system.
    c. Cost for the procurement of Drugs by NHIB and TCIG (included in Primary Health Care cost)
    d. NHIB cost for the procurement of clinical services from the private health sector
    e. Cost for the procurement of Medical Services overseas

2. Hospital utilization data at least at service level. This will be used to see how the burden of service can be shifted or properly planned for.

3. Drug utilization data

    a. Cost
    b. Utilization by diseases
    c. Procurement policy

4. Overseas treatment utilization and cost

    a. Utilization by nationality / employment status
    b. Utilization and cost by country
    c. Case distribution by diagnosis and cost

5. Overseas and in-country hospital cost associated with those persons who were uninsured and classified as Ward of the State.

6. NHIP enrollment data

    a. # of members
    b. # of beneficiaries
    c. # of dependents

7. NHIP revenue data from non-TCIG source save for that as an employer

8. Private sector expenditure on the provision of health care services locally

9. Other data